Diarrhea Nursing Care Plan

Patient information		
Patient name: Robert Smith		Age: 68
Gender: Male	Date of birth: 09/22/1955	

Medical history

- Diagnosed with ulcerative colitis 10 years ago
- Type 2 diabetes (well-controlled with oral medication)
- Hypertension
- Recent antibiotic use for a urinary tract infection

Assessment

Subjective	Objective	
- Patient reports 6-8 watery stools per day for the past 3 days - Complains of abdominal cramping, rating pain as 5/10 - Reports feeling weak and dizzy when standing up - Decreased appetite, but no nausea or vomiting - Concerned about dehydration	**Test/s**	**Result/s**
	CBC	WBC 11.2 x 10^9/L (slightly elevated), Hct 44% (normal)
	Electrolytes	Na+ 133 mEq/L (low), K+ 3.3 mEq/L (low)
	Stool culture	Pending
	C. difficile toxin test	Negative

Nursing diagnosis

1. Diarrhea related to inflammatory bowel disease exacerbation and recent antibiotic use, as evidenced by frequent watery stools and abdominal cramping.
2. Risk for deficient fluid volume related to excessive fluid loss through diarrhea, as evidenced by decreased skin turgor, dry mucous membranes, and electrolyte imbalance.
3. Acute pain related to gastrointestinal inflammation, as evidenced by patient's report of abdominal cramping rated 5/10.

Goals and outcomes	
Long-term	**Short-term**
Patient will achieve normal bowel pattern (formed stools 1-2 times per day) within 2 weeks.	Patient will report a 50% reduction in stool frequency within 3 days.
Patient will maintain adequate hydration and electrolyte balance throughout treatment.	Patient will demonstrate improved skin turgor and moist mucous membranes within 24 hours.
Patient will verbalize understanding of dietary management for ulcerative colitis within 1 week.	Patient will report pain levels of 3/10 or less within 48 hours.
Nursing interventions	**Rationale**
Monitor and record stool frequency, consistency, and volume every shift.	To track progress of diarrhea and effectiveness of interventions.
Administer prescribed anti-diarrheal medications as ordered (e.g., loperamide).	To reduce stool frequency and improve consistency.
Encourage oral fluid intake, aiming for 2-3 liters per day, including electrolyte-rich fluids.	To prevent dehydration and correct electrolyte imbalances.
Provide education on proper hand hygiene and its importance in preventing spread of infection.	To reduce risk of contamination and transmission.

Evaluation
- Reassess stool frequency, consistency, and volume daily - Monitor vital signs, skin turgor, and mucous membrane moisture every 4 hours - Evaluate patient's understanding of dietary management and medication regimen - Assess effectiveness of pain management interventions - Monitor daily weights and input/output

Additional notes
- Patient's wife is primary caregiver and is actively involved in care; include in education sessions - Patient expressed anxiety about potential ulcerative colitis flare-up; consider psychology consult if anxiety persists

Nurse’s information
Name: Sarah Thompson, RN, BSN
License number: RN789012
Contact number: 555-987-6543